



10 Reality Therapy

*William Glasser and
Robert E. Wubbolding*

Reality therapy is a method of counseling and psychotherapy developed originally by William Glasser, a psychiatrist.

Control theory, which serves as the basis of reality therapy, regards human beings as motivated to survive and to fulfill four basic psychological human needs: *belonging, power, fun, and freedom*. Human behavior is seen as based on choices.

Reality therapy helps people examine their wants and needs, evaluate behaviors, and make plans for fulfilling needs. It is mostly free of obscure psychological terminology, which leads to the misconception that it is easy to put into practice. Nevertheless, it is a practical method that can be used by therapists, counselors, teachers, parents, and others.

◆ OVERVIEW

Basic Concepts

The purposes of undergoing psychotherapy are generally to gain insight, to see connections, and to reach a higher level of self-awareness. The primary goal of reality therapy is neither insight nor resolution of unconscious conflicts. Rather, the desired outcome is behavioral change resulting in greater need satisfaction. People enter psychotherapy because they feel that something has gone wrong in their lives. The reality therapist believes such people are not fulfilling their

needs effectively, and thus they feel discomfort, anxiety, depression, guilt, fear, or shame. Others act negatively or develop psychosomatic symptoms. If they are comfortable with their behavior, but others believe they have problems, they are often coerced into therapy. Often such a person does not want to change, at least in the beginning of the therapy process. Yet, through the skillful use of reality therapy, it is possible to help a person evaluate whether behavioral change is desirable and possible and whether adjusting to the demands of the “real world” would be appropriate and satisfying. If clients decide that change is beneficial to them, they are helped to make better choices designed to maintain or increase their need fulfillment.

Reality therapy is based on control theory, a system of brain functioning (Powers, 1973). Glasser (1981, 1985) adapted this theory to the clinical setting and formulated it in a way that makes it useful to therapists, counselors, and others. Control theory states that the human brain functions like a thermostat that seeks to regulate its own behavior (much like a furnace or air conditioner) in order to change the world around it. Adding to the highly theoretical work of William Powers (1973), Glasser saw the human being as motivated by five internal forces. These human needs are innate, not learned; general, not specific; and universal, not limited to any specific race or culture. All behavior is aimed at fulfilling the four psychological needs of belonging, power, fun (or enjoyment), and freedom, as well as the physical need for survival. Effective satisfaction of these needs results in a sense of control that other theories refer to as self-actualization, self-fulfillment, or becoming a fully functioning person.

All sensate creatures, from primitive life forms to human beings, have a need to stay alive and to reproduce. Many behaviors are related to this need, such as the inner functioning of the organism. The working of the autonomic nervous system, as it controls the motor functions of the heart, glands, digestion, and all other internal organs, attempts to maintain life and satisfy the need for survival. Generally labelled the “old brain,” it keeps our body machinery functioning.

Psychological needs are located in the cerebral cortex, or “new brain.” The cerebral cortex functions for the most part at the level of awareness and regulates our voluntary behaviors as well as some routine behaviors such as walking. Creatures high on the evolutionary scale attempt to congregate and have a need for belonging. Because of this need, they learn to cooperate and function as a unit, finding belonging in families, schools, jobs, social clubs, and religious organizations. One of the goals of psychotherapy is to help clients fulfill this basic human drive.

Furthermore, human beings seek power in the form of achievement, competence and accomplishment. The need for power does not imply the exploitation of another person. And although power prompts human beings to compete, it is not true that when someone fulfills a need for power, someone else must lose power. Satisfying the need for power involves accomplishment or achievement. Another goal of psychotherapy is to assist clients to fulfill their needs for power without diminishing anyone else’s right to do the same.

Human beings also have a need for fun or enjoyment. Infants seek out comfort. Children spend a major part of their time having fun. Effective fulfillment of this need results in the opposite of boredom, apathy, and depression. Aristotle defined a human being as a creature who is “risible,” that is, one that can laugh. The word “fun” as used here does not mean “silliness.” Rather, it refers to enjoyment or pleasure. Consequently, one of the goals of reality therapy is to help people fulfill the need for fun or enjoyment within reason and without infringing on the right of others to meet this same need.

The last psychological need is freedom, independence, or autonomy. The need for independence implies that if human beings are to function in a fully human manner, they must have the opportunity to make choices and to act on their own, without unreasonable

restraints. Thus, another goal of reality therapy is to help clients find need-satisfying options for realizing autonomy.

As human beings interact with their environment, some parts of the external world satisfy the four psychological needs, while other parts do not. Consequently, each person assembles a mental file of wants. These are specific images of people, activities, objects, events, or situations that are need-fulfilling. Because they are appealing, they are said to have high quality. The conglomerate of these “wants” is the world a person would like to live in. The phrase “quality world” aptly describes the collection of wants related to the five needs. Each of these quality images or wants is specific. They are sometimes referred to as “pictures” and the conglomerate as “the mental picture album” (Glasser, 1985).

When a person perceives that he or she is getting what is desired from the external world, the five needs are satisfied. But when there is a difference between what is desired and the input one receives by way of the perceptual system, the person is motivated to generate a choice, a behavior in the external world. Therefore, behavior serves to close the gap between what a person wants and what a person has at a given moment.

The behavior generated is always composed of four elements: actions, thinking, feeling, and physiology (digestion, breathing, circulation, and so on). Total behavior is teleological or purposeful, designed to maneuver the external world so that wants and needs are met.

The input desired from the world enters the brain first through the sensory system and then through two filters: the total knowledge filter, by which the perception is first recognized, and the valuing filter, by which the person makes a positive or negative judgment about the perception. The thousands of perceptions stored in the mind are kept in the perceived world or what is sometimes called the “all we know world.” When a desired perception (want) is compared with a current perception of what a person has, behavior is generated. Thus, the output and the input constitute a loop. Behavior is generated toward the world for the purpose of gaining a specific input or perception.

A simple example illustrates the output-input loop of control theory. Leslie walks to the kitchen and takes a drink of water. This ordinary event, like more complicated behaviors, can be seen in the context of needs, wants, perceptions, and behaviors. Leslie has a need for survival, based on the experience of thirst. The need leads to a drive that prompts Leslie to quench her thirst. She compares her present condition of thirst with her want for comfort. Thus, her mental scale is out of balance. Because of this internal motivation, she chooses a total behavior: walking to the kitchen to get a glass of water. Her behavior is described as “total” because it contains four basic psychological elements: *action* (walking), *thinking* (internal self-talk: “I want a drink”), *feeling* (the satisfaction of quenching her thirst), and *physiological behavior* (swallowing). Having completed this effective total behavior, her perception of what she has matches what she wants and she is now in equilibrium or homeostasis.

Because the theory and practice of reality therapy are based on conscious behavior, wants, needs, and perceptions of human beings, they are applicable in virtually every setting. People marry and form intimate relationships to fulfill their need for belonging. But often, after a while, conflict arises over the need for power. In an age of equality between genders, wants and behaviors related to the power need become more evident and pronounced. In relationship therapy, each person is asked to examine his or her own wants, behavior, and perceptions, evaluate them, and make more effective plans.

Other Systems

Reality therapy has been compared to the rational emotive behavior therapy of Albert Ellis. While there is some overlap between the two theories, there are also significant

differences. Reality therapy and rational emotive behavior therapy share the principle that outside forces do not cause stress, depression, anxiety, or any other disturbance. They overlap in their belief that the current life of the client is paramount and endless scrutinizing of past experience is useless. Reality therapists, however, emphasize that behavior is a *choice*. Just as ineffective, harmful behaviors can be selected to satisfy a specific want related to a need, so too, effective alternative behaviors can be chosen in the future. The reality therapist emphasizes choice as a means to more effective living, rather than requiring a change in thinking as a prerequisite. Thinking is seen as only one component of the behavioral totality.

A significant difference between the two systems is the emphasis on human needs as sources of human behavior. Human beings attempt to fulfill their needs from moment to moment and never fulfill them completely. Rational emotive behavior therapy is based on the principle that we are human because we can think and that when human beings are disturbed, they are not thinking rationally. Reality therapy, on the other hand, states that thinking is a behavior generated from within, accompanied by actions, feelings, and physiological changes. This “total behavior,” of which thinking is only one part, has a clear purpose—to fulfill the five needs.

Reality therapy, based on control therapy, is very different from the operant conditioning of B. F. Skinner and the classical psychoanalytic approach of Sigmund Freud. From the perspective of the reality therapist, operant conditioning (and, to some extent, other behaviorist theories) neglects the inner control of clients and may even deny the existence of human needs. Albert Bandura allows for cognitive processes, but human needs are not an important part of social learning theory or the mediation model of behaviorism. However, effective techniques such as systematic desensitization and flooding can be used by the reality therapist, because the client gains a sense of control over his or her symptoms and is able to relinquish them when the results of surrendering the symptom become more need-satisfying than retaining it.

The cognitive behaviorism of Donald Meichenbaum and others is similar to reality therapy in that it embraces thinking and actions as important components of change. Yet change in any component of the behavioral system, in the view of reality therapy, requires a searching self-inventory or self-evaluation and the realization that one's current way of life is not effective. Thus, clients receiving treatment in reality therapy genuinely restructure their thinking by changing their judgment about aspects of their lives.

Reality therapy rejects many of the basic assumptions of psychoanalysis and the psychoanalytic method. Because reality therapy sees behavior as a person's best attempt to fulfill current human needs, it rejects the “reactive terminology” that disturbances are due to outside forces or past events. Thus, anxiety, phobias, and even psychoses are believed to be the result of unmet needs and wants. Even though some limited discussion of past experiences is acceptable, the reality therapist encourages clients to discuss what they can control—their current actions, thinking, and feelings.

It is important to note that because current behaviors are seen as choices, it does not follow that better choices are readily available to the client. Quite the contrary is true. A client, raised in a dysfunctional family, will respond to that environment. This may be the only choice available at the time and thus represents the client's best attempt to fulfill wants and needs. The therapist's role is to help the client develop more satisfying choices. If clients could easily make other choices, they would not need therapists.

William Glasser has acknowledged similarities between reality therapy and Adlerian therapy (Evans, 1982). There are many areas of agreement and many ways in which the two theories are quite different. Harold Mosak (1989) stated that Adlerian therapy changes the questions, “How do heredity and environment shape the individual?” to “How does the

individual use heredity and environment?” (p. 77). Reality therapy is in complete agreement with this question and extends it to “How can an individual make better choices to fulfill the five needs without infringing on the rights of others who also seek to fulfill their wants and needs?” Adlerians study the family constellation and emphasize early experience. In contrast, birth order is unimportant to the reality therapist. The current wants, perceptions, and behaviors of the client vis à vis the other family members are of paramount importance, irrespective of how they were developed in the past. The emphasis for the reality therapist is on the “here and now.”

The reality therapist helps the client to see how he or she is fulfilling the five human needs, one of which is power. This is similar to the Adlerian view of the person seeking significance. Even as children we seek to excel, to gain recognition, and to be competent. These efforts fulfill the need for power or achievement, as seen in reality therapy.

In the process of therapy, there are also some differences between reality therapy and other systems. Reality therapists see dreams as behaviors, but they are of little therapeutic value because they can't be controlled. In addition, the insight gained in reality therapy is not simply that there is some underlying dynamic causing a particular behavior, but more profound and far-reaching realizations such as “I am responsible,” “I can make a change,” “I cannot change others,” “My current behavior is not helping me,” and so on.

On a superficial level, reality therapy appears to be at odds with person-centered therapy. Reality therapists emphasize action, questions, and a therapist-led approach. Carl Rogers stressed feelings, reflective listening, and a client-initiated agenda. In reality therapy, an attempt is made to take the lead and actively encourage specific changes. Though it is not heavy-handed or coercive, it is markedly different from the style of a person-centered therapist who follows the lead of clients and is more inclined to wait for clients to decide to change. Thus, while it is true that therapy sessions conducted by a reality therapist would be very different from those conducted by a person-centered therapist, on a more profound level there is a common bedrock. Common beliefs include the essential goodness of human nature, the personal responsibility of human beings, the purposefulness of behavior, and the importance of trust and authenticity.

In general, reality therapy is most similar to those systems of therapy that see the client as inner-directed. Systems emphasizing the influence of parents, environment, past experience, and the unconscious, all of which minimize the present ability of the client to change, are most unlike reality therapy.

◆ HISTORY

Precursors

William Glasser created reality therapy based on his experience with clients. Almost all of his training, however, came from conventional psychoanalysis. As the concepts of reality therapy emerged, Glasser rebelled against his formal training and noticed that many of his teachers did not practice what they taught. As they demonstrated by their interactions with patients, he noticed that what seemed to work was not what was said to work. What was actually done in effective therapy was often much closer to what later became reality therapy.

One of his few nonanalytical teachers, G. L. Harrington, encouraged Glasser to put his ideas into practice and to discuss his thoughts. Harrington became Glasser's mentor and helped him to formalize reality therapy in the early 1960s. Harrington was influenced by Helmuth Kaiser, a psychoanalyst who had worked with Harrington in the 1950s at the Menninger Clinic, and who also had begun to turn away from conventional analysis.

Beginnings

Reality therapy began when Glasser became dissatisfied with psychoanalytic psychiatry as taught at the Veterans Administration Brentwood Hospital and at the University of California at Los Angeles. What disturbed him most was endless ruminations about how the patient's behavior was "caused" by others in the patient's family or by a "harsh" world. The patient was generally seen as a victim of forces beyond his or her control, and the role of the analyst was to give the patient insight into his or her unconscious so he or she could regroup and cope. Even when patients gained insight after insight and when transferences were worked through, the patients stayed the same or even became worse, taking less responsibility for what they did.

On his own, Glasser began to focus on the present and to try to get patients to realize that they were responsible for what they did, they had to change themselves, and they could not count on others to change or help them, no matter how much insight they gained. For example, one woman had been attending the clinic for three years and had spent most of that time blaming her nervousness and depression on her now-dead grandfather. Glasser told her that he would see her only if she would never again mention her grandfather. She was shocked and responded, "If I don't talk about my grandfather, what will I talk about?" Glasser told her to talk about what she was doing now in her life to solve her problems, because her grandfather was dead and no longer had anything to do with her life. In a few short months, even with this early crude version of reality therapy, the woman stopped depressing and anxietying (control theory behavior terms) and started doing many things to fulfill her needs. She had taken control of her own life. For three years traditional therapy had deprived her of the chance to help herself.

Donald O'Donnell (1987) described how Glasser explained his unorthodox move to his residency consultant, G. L. Harrington. Instead of reprimanding Glasser, Harrington shook his hand and said, "Join the club." This started a seven-year relationship during which Harrington continued to consult with Glasser and helped him formulate the ideas that became reality therapy.

In 1965, Glasser became a consultant to the Ventura School, a California Youth Authority institution for delinquent girls, where the young women had all been told that they were emotionally disturbed and were not responsible for their lawbreaking. The people who ran the school were upset by this view and supported Glasser in his attempt to introduce the beginnings of reality therapy into this and other Youth Authority institutions.

Current Status

At present, reality therapy is recognized as an effective therapeutic modality with many applications. For example, an unpublished document of the Department of Defense used at a 1981 conference on drug abuse in the armed forces stated that over 90% of the more than 200 armed forces clinics that treat drug and alcohol abuse use reality therapy as their preferred therapeutic approach.

The Institute for Control Theory, Reality Therapy, and Quality Management in Los Angeles, founded in 1968, promotes the teaching of reality therapy applied to psychotherapy, counseling, schools, agencies, and management. A certification process was gradually developed, and in 1975 the first certificates were given for the practice of reality therapy.

The title Reality Therapy Certified (RTC) is given to persons completing an 18-month training program. This program consists of workshops, supervised practice, video and audio taping, small group practice, feedback, and other experiences.

The Institute for Reality Therapy administers the certification process. In 1988, Glasser asked Robert E. Wubbolding to become the first director of training for the Institute. In this capacity, Wubbolding monitors the certification process and the faculty training programs.

Much of the work of practitioners of reality therapy extends beyond the world of psychotherapy. In 1968, Glasser wrote *Schools Without Failure*, in which he asserted that when children are unable to control their world successfully (i.e., succeed in school), it hurts so much that they often stop trying to learn. At the present time, the Institute for Reality Therapy and its instructors teach the concepts in Glasser's *The Quality School* (1990b) to schools in the United States and elsewhere. In this groundbreaking work, Glasser applied the ideas of W. Edwards Deming (1982) to education. The major problem underlying the educational system is not the disruption of the students, poorly paid teachers, unused computers, lack of community involvement, or dozens of other problems. Rather, these problems are symptoms of the simple but overlooked fact that Americans have settled on mediocre work, behavior and efforts on the part of students. If the nation is indeed at risk, it is because of lack of quality education. Glasser believes that control theory and reality therapy, if taught properly, can enhance the quality of performance in schools. In a quality school, everyone has been trained to use the principles of Deming and Glasser. Schools interested in these principles have formed a consortium numbering well over 200 schools as of 1995.

Still, reality therapy remains the counseling and therapy tool that it was from the very beginning. It is taught in many countries besides the U.S. and Canada, and the Institute has ties to Japan, Korea, Ireland, Norway, the United Kingdom, Australia, New Zealand, Hong Kong, Singapore, and the former Yugoslavia.

Since the publication of Glasser's *Stations of the Mind* (1981) and *Control Theory* (1985), thousands of persons have heard about control theory and its delivery system, reality therapy. Moreover, Glasser has reconceptualized the essentials of reality therapy under two general categories: environment and procedures (1990a). Robert Wubbolding (1992) has extended these ideas by describing them as a cycle of therapy and the WDEP system (Wants, Doing, Evaluation, and Planning). Robert Cockrum (1989) stated, "William Glasser has never been content to allow his theories to be taught or used without constant scrutiny, addition and sometimes even major changes."

In 1981, *The Journal of Reality Therapy* was launched, edited by Lawrence Litwack. Since that time, more than 200 essays, articles, and research studies have been published on the applications of reality therapy.

As of 1994, nearly 4500 people had completed the reality therapy certification process worldwide, with the numbers increasing each year. Reality therapy has seen a slow but steady increase in acceptance as a viable and respected psychotherapy theory and educational system.

◆ PERSONALITY

Theory of Personality

Reality therapy, based on control theory, views the human brain as a system that seeks to manipulate the external world, and explains the development of human personality as an attempt to fulfill five innate drives: belonging, power, fun or enjoyment, freedom, and physical survival. From the cradle to the grave we generate behaviors, and through experimentation we find them need-satisfying or need-threatening. As these behaviors influ-

ence the external world, we learn that other persons, events, objects, and situations are either need-satisfying, need-threatening, or neutral.

Choice and Discovery

Reality therapy teaches that human beings choose behaviors. When choices are made, people discover that the result attained is desirable or undesirable. They thus discover whether their behaviors are effective or ineffective in satisfying their needs. They also discover whether particular aspects of the external world are pleasurable (need-satisfying), painful (not need-satisfying), or neutral.

Infants “choose” the only behavior available to them when they attempt to fulfill their physiological needs related to survival, specifically comfort and hunger. As children grow, they discover that other behaviors are available. They see other people smiling, talking, walking, reaching, touching, and playing and then choose some of these behaviors at appropriate developmental and maturational points as more effective ways to fulfill their needs.

Personality Development and Identity

Glasser (1972, 1985) has described two general types of human personality. These are explained primarily in terms of how individuals see themselves and secondarily in terms of how others see them. All persons generate behaviors to fulfill human needs. As people attempt to accomplish various developmental tasks, they either succeed or fail. When they habitually fail to fulfill their needs effectively, they develop a failure identity (Glasser, 1972, 1985) characterized by ineffective or out-of-control behaviors.

Failure Identity, Less Effective Life Direction

Three stages of regression are characterized by identifiable total behaviors.

Stage 1: Giving up. This occurs when a person is unable to fulfill his or her needs effectively. Thus, when a student fails to develop effective behaviors, he or she may decide that the only choice is giving up.

Stage 2: Choosing negative symptoms. The “giving up” stage of failure is often a prelude to additional failure and further ineffective behaviors such as (a) anti-social actions, (b) negative thinking, (c) negative feelings such as depression, and (d) negative physiological conditions, such as psychosomatic disorders.

These negative symptoms, although ineffective, are still the clients’ best efforts at a given moment to fulfill their needs. The role of the reality therapist is to help clients choose other actions, thoughts, and feelings. This occurs after helping them define their Wants, describe what they are *Doing* (total behavior), *Evaluate* their behaviors, and *Plan* for a better future (*the WDEP system*).

Stage 3: Negative addictions. Some persons regress beyond negative symptoms and perceive even more ineffective behaviors as need-satisfying. These behaviors produce, at least in their early stages, an illusion of immediate need satisfaction. They can provide a “high” that includes a short-term sense of belonging, power, fun, and freedom. Alcohol, drugs, gambling, food, even an addiction to work can all provide a person with a

distorted and momentary sense of popularity, power, excitement, or liberation from stress and pain.

Success Identity, More Effective Life Direction

Just as the human personality can be characterized by a sense of failure, an ineffective or destructive life direction, and out-of-control behaviors, so too the personality can develop in the opposite direction and achieve health and success. An individual growing in this direction possesses a willingness as well as a repertoire of skills for meeting the five needs of belonging, power, fun, freedom, and survival in positive ways. Glasser (1972) describes this kind of person as having a success identity. Wubbolding (1988) has completed a positive developmental model that is the mirror image of the failure identity as characterized by giving up and negative symptoms. These positive stages are described below.

Stage 1: "I want to change, and I want to grow." The desire to fulfill human needs effectively without infringing on the rights of others represents the first stage in the development of a healthy personality.

Stage 2: Positive symptoms. The second stage in the development of success identity and an effective life direction is the mirror image of negative symptoms. These positive symptoms include (a) altruistic actions, (b) effective thinking, such as "I can" or "I am a valuable person," (c) positive feelings, such as self-confidence, enthusiasm, and trust, and (d) effective behaviors, such as a healthy diet and exercise.

Stage 3: Positive addictions. Relatively few people are able to reach a state of "positive addiction." This condition, the opposite of the negative addiction described above, is the result of explicit, life-enhancing choices. Although other activities can create mental states that approach the positive addiction state, Glasser (1976) found two activities especially helpful in achieving the conditions necessary for positive addiction: meditation and non-competitive exercise. These two behaviors involve all the following conditions of a positively addicting activity.

1. The activity occurs regularly, such as running on an almost daily basis for a limited amount of time, usually 45 to 60 minutes.
2. An altered state of consciousness or natural "high" accompanies the activity for short periods of time.
3. The activity requires little concentration. On the contrary, the mind is freed from the responsibility of attending to procedures, rules, and even ideas.
4. Cessation of the activity is painful or uncomfortable.

Even though few people reach the positively addicted state, many enhance their personal growth by activities that share some of the qualities of pure positive addiction. Such activities include travel, reading, walking, and other habitual enjoyment-related behaviors.

In the view of reality therapists, endless discussions of diagnosis, past history, and external uncontrollable events are not effective in achieving desired changes. While such discussions are interesting to the therapist and necessary at times, they precede the *most* effective use of reality therapy, which consists of building on already existing effective behaviors by eliciting a commitment to change, defining what is realistically attainable, help-

ing the client conduct a searching and detailed self-evaluation, and making specific plans for life enrichment as represented by the stages of growth.

Variety of Concepts

Reality therapy is a logical, common-sense system. It requires that the therapist have a sense of direction and a knowledge of the components of a healthy personality. It is not a system by which change automatically occurs if the therapist labels a problem, helps the client gain insight, or analyzes the past. It is similar to the work of an artist who, following some basic principles, uses creativity to produce a unique work of art.

Language

In formulating the principles of reality therapy, a conscious decision was made to use easily understood words. The use of simple words such as *belonging*, *power*, *fun*, *freedom*, *choices*, *wants*, and *plans*, is not an accident. The happy result of this effort has been to introduce basic concepts of mental health to new audiences. Yet this demystification and relative understandability of the concepts is a two-edged sword, and the principles of reality therapy are more difficult to practice than to understand.

Psychopathology

Reality therapy recognizes the importance of diagnosis but views psychopathology in terms of behaviors rather than static conditions. Thus, people do not exist in an immutable *place* when they are depressed. Rather, clients are said to be “depress-ing,” “anxiety-ing,” “guilt-ing,” “phobic-ing,” “compuls-ing” “headach-ing” and “sick-ing” themselves. *To reframe such phenomena from conditions to behaviors is to see them as more controllable.* Alternatives can be sought. Clients are not passive victims of these oppressive problems, but are generators of behaviors. Nevertheless, they are not blamed or criticized for their behavior, as they can generate only the behaviors that are available to them. The reality therapist, using the WDEP (Wants, Doing, Evaluation, Planning) system, assists them to develop better, more need-satisfying behaviors.

Multicultural Applications

Most psychotherapies originated in the western hemisphere, many of them in North America. Reality therapy began as an American theory applied to the many cultures of the United States and Canada. It is now taught, studied, or practiced in varying degrees in many countries. Because of its application to many other cultures, the practice and teaching of reality therapy needs to be adjusted when people’s values, wants, and manner of expression are quite different and usually more indirect than in North America. On the surface, reality therapy is a very direct method, yet it needs to be used more indirectly in “indirect cultures.”

In some cultures in the Pacific Rim, for example, psychotherapists are seen not as partners but as authority figures. Maintaining a delicate balance between practicing and teaching the theory accurately and authentically, on one hand, and adapting it to “other” cultures requires sensitivity to the culture as well as knowledge of the social, economic, historical, political, and psychological processes of the individual culture. For example, in helping an American student evaluate her own behavior, the therapist might emphasize questions such as, “Is what you are doing helping or hurting you?” “Do your current actions

have a reasonable chance of getting you what you want?” In counseling a Chinese youth in Singapore, it would be appropriate to ask similar questions, but more emphasis should be placed on questions such as, “What does your family think about your actions?” “Do they approve or disapprove?” “Do your actions bring shame or honor to your parents?”

Reality therapy requires specific skills and procedures, as summarized in the WDEP system. Nevertheless, these should be seen as flexible and adaptable to the style and personality of the user as well as the experience, manner of expression, thought patterns (total behavior), and specific wants of members of various cultures.

◆ PSYCHOTHERAPY

Theory of Psychotherapy

Based on the principle that human beings are born with at least five generic needs already discussed, reality therapy provides a structure for helping clients more effectively satisfy their needs for belonging, achievement, fun or enjoyment, independence or freedom, and survival. Thus, the overall goal of the practitioner is more effective need satisfaction by the client.

Purposeful Behavior

Behavior is the mechanism used to fulfill human needs. Marcus Aurelius, perhaps the first control theorist, stated, “Nature has an aim in everything.” We all act as sculptors molding the clay of our own behaviors in an attempt to shape the world around us to match the image of what we want. The age-old vaudeville joke is quite true—the chicken *does* cross the road to get to the other side. Likewise, the human behaviors of acting, thinking, feeling, and even “physiologic-ing” serve a purpose, have an aim, and are teleological. Their purpose is to fulfill human needs.

Behavior as Choice

One of the most empowering aspects of reality therapy is experienced by clients when the reality therapist repeatedly speaks of “choice.” While the word is not used with an identical meaning for all behaviors, it is useful to discuss with clients the degree of choice that they perceive available to them. And though they cannot instantly choose to make radical changes in their feelings or thoughts, they can make small, incremental changes in their behavior. Over a period of time, these changes result in changes in feelings, thinking, and, at times, even physiological or health-related behaviors. Consequently, reality therapists totally reject the notion that human beings are victims of external stimuli or conditioning that allow little or no choice.

Emphasis on Present

Since choice is a “here and now” phenomenon, the therapist emphasizes current and recent life-style behaviors. It is true that our personal history is important and interesting, and our current life and our direction for the future are the sum of all that we have experienced. Still, as Glasser frequently points out in his lectures, we do not need to find the nail that caused the tire of a car to lose its air. Past behavior should be discussed only as it impacts on present choices or future behavior.

Role of Therapist

Whether to lead the client (for example, by asking questions) or to follow (for example, letting the client speak without interruption) is an individual decision of the therapist and will vary across settings and situations. The use of reality therapy with a grieving person is quite different from its use with an habitual drunkard who denies being an alcoholic and blames others for his problems. In the former situation, the therapist would listen supportively and gently help the client take better charge of need-satisfying actions. In the latter situation, the therapist might be somewhat confrontive, feeding back specific behaviors and asking for dozens of self-evaluations.

But no matter what the setting, the practitioner creates an environment that is firm, friendly, and conducive to change. Sometimes this is accomplished quickly, but more often it is the result of *continued* effort. A system of therapeutic interventions, in which the client sees the therapist as a need-satisfying person, is built upon this foundation, and these basic principles comprise the essence of the practice of reality therapy (Wubbolding, 1991a).

Environment

The atmosphere in the counseling relationship is one of firmness and friendliness. The ideal relationship is a partnership in which both client and therapist struggle to find more effective behavioral patterns for the client. Therapists use many skills in this endeavor, some of which are common to other therapeutic methods, e.g., attending behaviors such as eye contact, verbal following, an ongoing awareness of nonverbal behaviors, valuing the client, creating a sense of hope for a better future, appropriate use of self-disclosure, using metaphors presented by the client, and working within the boundaries of professional ethics.

These skills, while not exhaustive, illustrate how the counseling relationship is enhanced in reality therapy. Setting the atmosphere is an ongoing process that continues throughout the relationship. Utilizing such procedures enhances the environment, and the distinction between environment and procedures is not absolute since each interacts with the other.

Process of Psychotherapy

Procedures

There are clearly identifiable interventions that constitute the essence of reality therapy. Glasser (1990a) said, "the art of counseling is to weave these components together in ways that lead clients to evaluate their lives and decide to move in more effective directions." Wubbolding (1991a, 1992) has formulated these components into the **WDEP system**, with each letter representing a cluster of skills and techniques for assisting clients to take better control of their own lives and thereby fulfill their needs in ways satisfying to them and to society.

W: Ask clients what they *want*. By skillful and persistent questioning, the therapist helps clients formulate, clarify, delineate, and prioritize the elements (desires) contained in their quality world of mental pictures. All human beings have specific wants related to each of their needs. Some wants are clear and non-negotiable, such as the desire for air.

Others are weak whims, such as selecting a specific pair of socks from a drawer. All are related to the five sources of human motivation, the needs for belonging, power, fun, freedom, and survival.

By means of questioning, therapists help clients describe what they want from themselves, from the world around them, from the therapy process, from parents, children, spouse, job, friends, associates, religion, and from any institution that impinges upon their lives. The clients are also asked to describe what they are getting and what they are not getting from each of these relationships.

The W refers not only to wants, but also perceptions. More specifically, the perceived locus of control (*the perceived source of control over one's behavior*) is discussed. The reality therapist, believing there is a high correlation between a perceived external locus of control and ineffective behaviors, helps clients ascertain how much control over their behavior they think they have now and have had in the past. Thus, one of the goals of therapy is to help clients perceive some inner control and realize that they can increase it by consciously getting the feeling that they are in charge and then changing their behavior.

D: Ask clients *what they are doing* and *their overall direction*. “Where are your current choices taking you?” “Are you headed in a direction where you want to be in a month, a year, two years from now?” “Will you describe the direction you are going without making a judgment about it?” These global questions are an attempt to help clients increase their awareness of what their choices look like “from a distance.” By describing their overall destination, clients become ready to evaluate and change their thinking and behavior.

E: Ask clients to conduct a searching *self-evaluation*. Glasser (1990a, 1990b) has described self-evaluation as the core of reality therapy. Wubbolding (1990) sees it as the keystone in the arch of procedures. It holds the other elements together, and if it is removed, the arch crumbles.

The many forms of self-evaluation include the following:

1. *Evaluation of wants as realistic.* Clients are asked to evaluate the attainability of their wants.
2. *Evaluation of wants as genuinely beneficial.* All wants are related to needs and thus appear to be need-satisfying and genuinely helpful to the client. Still, many people have desires which, upon further examination, are found not to be truly advantageous to their welfare. Consequently, clients are asked to evaluate wants in terms of their short- and long-range impact on themselves, on others, and on their environment.
3. *Evaluation of behavioral direction.* Clients are asked to examine whether their overall life journey is headed toward a desirable destination.
4. *Evaluation of specific actions.* The most commonly used form of evaluation is a judgment made about the effectiveness of specific actions. The student is asked, “Did your procrastination help you study for the test?” On the other hand, a parent might be asked “What impact did lecturing your child about school three times a day have on him? Did it help? What did it do to you and to the family?” A husband and wife could be evaluated with inquiries such as, “If you don’t talk to each other, or avoid each other as you said you did yesterday, will you get what you said you want—a happier marriage?”
5. *Evaluation of perception.* After helping clients describe their perceptions of the current situation, especially their perceived locus of control, the reality therapist asks clients to decide if the way they see the world is genuinely the best for them. “Is it true that you

really have no control, that you are completely incapable of making the situation better?” “By doing just enough to slide by, are you achieving the highest quality behavior you are capable of?” “If you haven’t caused any of the trouble you’ve experienced, is there any way you could make the situation worse?” Most clients enjoy telling the therapist that they could indeed choose to worsen their plight. With such paradoxical questioning, they come to realize that if they can make life more miserable, they have more control than they at first thought, and can thus improve their condition.

6. *Evaluation of the plan of action.* One of the hoped-for outcomes of therapy sessions is the formulation and execution of action plans. Clients are asked questions such as, “If you follow through on your plans, how will your life be better? How will you be living a more need-satisfying life? What specifically will you have, in terms of inner need satisfaction, that you don’t have now?” Also, the plan is evaluated using the criteria of an effective plan, to be described later.

7. *Professional self-evaluation.* Part of this procedure is the inner self-evaluation of the therapist including such questions as: “How am I facilitating my own professional growth? Do I work within the boundaries of my limitations? How committed am I to my profession and to this particular client? Am I aware of the special ethical applications of reality therapy? Is the quality of my service to the public the highest it can be? How can I improve it?”

The therapist’s continual self-inspection is a cornerstone of the effective use of reality therapy. If therapists are to be skilled in helping others confront their own wants, actions, thoughts, feelings, and motivational level, it follows that therapists must be willing to engage in the same process.

The goals of reality therapy are behavioral changes, personal growth, improved and enhanced life-style, better decision making, remediation of personal deficits and, in the language of control theory, the more effective satisfaction of the human needs of belonging, power, fun, and freedom. Human beings will make changes after they decide that a change would be advantageous. Thus, reality therapists are relentless in their efforts to help clients conduct explicit self-evaluations of each component of their control systems.

P: Ask clients to make *Plans* to more effectively fulfill their needs. When clients make plans and follow through, they are taking charge of their lives by redirecting their energy. The therapist facilitates plan formulation by teaching clients that successful plans have several characteristics. The plan should have SAMIC characteristics—i.e., it should be Simple, Attainable, Measurable, Immediate, and Committed to.

The most effective plans are those originating with the client. When clients answer the question, “What is your plan?” with a detailed strategy for change, they are clearly taking better charge of their life and its direction. Still, many clients, especially in the initial stages of counseling, are unable to formulate such plans. Consequently, the reality therapist often assists actively in helping clients make plans.

The procedures used in the effective practice of reality therapy have wide application to virtually every type of client, and their use is limited only by the creativity of the practitioner. Because behavior is seen more as ineffective than pathological, the therapist spends a minimal amount of time discussing problems and a maximum amount of time exploring better ways to fulfill needs. Even a psychotic person exhibits some effective behavior. This behavior receives the attention and interest of the therapist. Every attempt is made to build on it and to expand it, while helping the client self-evaluate both less

effective and more helpful behaviors. The same can be said of other applications. Drug abuse, depression, low self-esteem, acting-out behaviors, and the entire catalogue of out-of-control behaviors can be discussed to some degree. But the procedures that are most helpful and most efficiently used are those that encourage clients to search out a positive lifestyle characterized by a wide range of habitual choices that are satisfactory to clients, to their families, and to society at large.

A typical first session of therapy is summarized below. It is assumed that ethical issues have been discussed as well as the therapist's credentials, informed consent, confidentiality and its limitations, and the rights and responsibilities of both client and therapist. In this dialogue, only the components of reality therapy are presented and the professional issues common to any therapy (such as rapport-building dialogue) are omitted.

Louis, age 39, unemployed for eight months, has been looking unsuccessfully for a job at the middle managerial level. His wife is employed, and they have two children, a twelve-year-old boy and a ten-year-old girl. On the telephone, Louis previously stated that he was still angry at his previous employer and depressed about not finding work. Family problems include long-standing tension between him and his wife, Sally.

- T: Louis, we've talked about the professional details and you said you understand them. You also gave me a summary of your situation on the phone. What do you want to accomplish as a result of therapy?
- L: I think if I found a job everything would be fine.
- T: You indicated on the phone that the "no job" situation is a major factor. What else is bothering you?
- L: I'm still angry at the company for letting me go. It just wasn't justified.
- T: What else is going on with you?
- L: I've searched for a job and gone to the out-placement firm. But not finding a job is getting me down. This just adds to the other problems.
- T: You hinted at other problems on the phone. Do you want to describe them?
- L: My wife and I haven't gotten along for a long time, probably three or four years. And it's had an effect on the children. They seem to be nervous, have low grades, and bicker more than most kids.
- T: So you have a number of issues to deal with: job, feeling better, and a happier family life?
- L: You describe them a little differently than I did.
- T: Oh, how?
- L: I'm not sure.
- T: Like framing them as goals to reach rather than merely as problems to overcome?
- L: Yes, that's it.
- T: As you hear them described in that way, what thoughts go through your mind?
- L: I've never thought of these problems as goals. I've thought of them as standing in the way of reaching my goals.
- T: From working with people, I've found that if they can think of their problems in a different way, the problems become more manageable.
- L: It's hard to think that way.
- T: Yes, it is and it won't happen merely because we agree that it is a good idea. But let me ask you this: Has thinking about your situation the way you've thought about it been helping you or holding you back?
- L: It's definitely held me back. I've been shackled by these problems.
- T: I like how you said that... "shackled." Let me try to understand that more. "Shackled." What does that mean?
- L: I've been imprisoned by this mess.
- T: Wait, that's a new idea. "Shackled" and in "prison." Even if you broke the bonds you would still have a wall to climb. Is that accurate?

- L: Right! I'm feeling trapped, cornered.
- T: So, if you chose to see your situation differently, would it help or hurt?
- L: It couldn't hurt.
- T: And it might help?
- L: Yes, But that's not the main problem. The problem is no job, wife and kids.
- T: Yet, for an instant, when you thought about your problem differently, how did you feel? Better or worse?
- L: I guess just a tiny bit better.
- T: That's interesting. Would you like to take that microsecond of change and extend it to minutes, hours, days, weeks, and even a lifetime?
- L: That's why I'm here.
- T: And that's why I'm here... To help you make it happen.
- L: Do you think it can happen?
- T: I believe it can. And I'm saying that, not as a wishful thought, but as evidenced by the microsecond we spoke of. There is already some solid proof. What do you think this tells you about the "shackles" and your "prison?"
- L: That I can get rid of the mess I'm in.
- T: Exactly, I agree. Now I want to ask you about something else. How hard is it to simply say, "I'll change how I think about my situation?"
- L: Well, I don't think it is very easy.
- T: I agree. It will be necessary to change your thoughts. You can sit around and think about a job all day, and I doubt if a job will find you. Thinking about it is good and helpful, but not enough. You need more specific choices.
- L: I'm an action sort of person. So, I'm not averse to doing something.
- T: So, tell me what you chose to do yesterday about these issues, or as you used to call them your "problems," "shackles," and "prison cell," "swamp," "quagmire," and "solitary confinement?"
- L: Did I say all that? The situation is not really that bad.
- T: Oh, so there's more hope than it seemed at first?
- L: Do you think there is hope?
- T: No doubt about it in my mind. I suppose I was exaggerating when I used all those labels.
- L: (Smiling wryly.) I got your point.
- T: It's good you can smile, even for a moment. So we've had two bits of data showing that you can feel better!
- L: You do look for even the slightest success!
- T: Yes, any successful choice is a step in the right direction. What's the saying? "A journey of a thousand miles is begun with one step."
- L: I've taken two steps.
- T: Actually, you've taken more. You also came here. That is a major step. You took action.
- L: Yeah!
- T: Now, let's talk about what happened yesterday. Describe your actions, starting in the morning.
- L: I got up about 10:00 a.m., looked through the paper, ate breakfast, watched TV, and loafed most of the day.
- T: Could you be more specific by describing in detail exactly what you chose to do? What precisely did you do?
- L: (Client elaborates on how he spent his time from 10:00 a.m. until bedtime at 10:00 p.m. For the most part, he was passive and did nothing towards accomplishing any of his goals.)
- T: Now, I'm going to ask you what might, at first, seem to be a simple and obvious series of questions. Are you ready?
- L: Yes.
- T: Did the way you spent your day yesterday help you or hurt you?
- L: It hurt. But in the afternoon I did do some things around the house that had to be done.
- T: And so what impact did the entire day have on your overall direction?

- L: My wife was glad I did a few things.
 T: So, doing things *for* her helps?
 L: Yes.
 T: So, that part was slightly helpful regarding the relationship with Sally?
 L: Yes.
 T: Did the rest of the day take you where you wanted to go?
 L: No, it was a waste.
 T: And if you continue to go in this direction, where will you be in six months or a year?
 L: Nowhere.
 T: Will you feel better or worse?
 L: Worse.
 T: What effect will it have on your marriage and on how you feel?
 L: Everything will be worse.
 T: Now, Louis, what do you want to come away with today from this session?
 L: A way to get out of this swamp.
 T: I believe you can. But one more question. How hard do you want to work at turning your life around?
 L: I would like to do it!
 T: Is that a “maybe” or an “I will”?
 L: “I will.”
 T: So what will you do differently tonight? What will you choose to do that is different from what you would have done if we had not had this conversation?
 L: (Client formulates a realistically attainable plan that helps him to move in a positive direction.)

The above dialogue illustrates various components of reality therapy: asking what the client wants and eliciting the client’s summary description of actions, thinking, and feelings with emphasis on the actions, the client’s self-evaluation and a minor plan. However, the main goal of the first session is deeper. If the procedures are used properly, the client gains a sense of hope. By using the WDEP system the client learns, as a side effect, that his life can improve and that he need not be locked in a psychological prison permanently. This underlying message of hope is the primary goal of the first therapy session.

Mechanisms of Psychotherapy

Reality therapy can help clients change because it is based on how people live from moment to moment. From the viewpoint of reality therapy, humans have more control over their actions, thinking, and feelings than they have been led to believe through the popular culture and certainly more than is reflected in some of the more traditional theories of psychology. Some of the more important components of change include the following.

More Effective Control and Need Fulfillment

When clients become aware of their general needs, they realize that everything they do, think, feel, and even their physiological functioning is an attempt to fulfill these needs. When they identify their sources of motivation, i.e., what they want related to their needs, their behavioral system is activated. They feel liberated and empowered when they make more effective choices. They no longer are imprisoned or victimized by the past. Consequently, a major part of reality therapy is helping clients develop, extend, clarify, examine, and verbally describe their specific wants related to belonging, power, fun and freedom.

Appropriate Environment

As with many theories of psychotherapy, the use of reality therapy includes the establishment of a friendly and safe atmosphere. A prerequisite to change in therapy is trust in the therapist. Through acceptance by the therapist, clients come to believe that they can speak without fear and tell their story without being criticized or blamed. Feeling appreciated, they are more willing to look deeper at the effectiveness of their specific behaviors as well as their overall life direction.

Client Self-Evaluation

All change, great and small, is preceded by the client's judgment that life is not as it could be and that a better, more rewarding future is possible. Explicit choice of more effective behaviors leading to improvement in relationships, career, and leisure can be attained only after explicit evaluation of current wants, behaviors, and perceptions.

In summary, change is facilitated by the effective use of reality therapy to establish an environment characterized by trust. This safe atmosphere allows clients to incorporate the therapist into their quality worlds and to see him or her as reliable, helpful and competent. Following this, the skillful use of the WDEP system helps clients choose more need-satisfying behaviors.

◆ APPLICATIONS

Problems

Reality therapy has been applied as a psychotherapy instrument, a personal growth program, a tool for managing or coaching employees, a classroom strategy, and an educational reform philosophy/strategy. It has been applied successfully to severe mental conditions such as bipolar disorder, catatonia, and depression. It has been used in marriage therapy and with suicide ideation and threats, family issues such as caring for elderly parents, identity issues, and school achievement (N. Glasser, 1980). Other areas in which reality therapy has been used successfully include child abuse, adolescent rebellion, incest survival, bereavement, parental relations, and eating disorders (N. Glasser, 1989), self-help (Good, 1987), mental health (Garner, 1983), and recovery programs (Reuss, 1985).

Reality therapy was based on outcome research from its very beginning. Glasser (1965) described the treatment of long-term hospitalized psychotic patients in the Veterans Administration Neuropsychiatric Hospital in Los Angeles, including 210 patients whose "problems were categorized into paranoid schizophrenia, catatonic schizophrenia, hebephrenic schizophrenia...and undifferentiated schizophrenia" (p. 131). These patients hallucinated, were delusional, and spent most of their time passively sitting and waiting. The average stay in the hospital for the 210 men was fifteen years. Two years after the reality therapy program was initiated, 100 of the 210 had been released.

Other studies have shown an increase in self-esteem, a reduction in court referrals (Shea, 1973), and improvement in classroom behavior (Hart-Hester, Heuchert, & Whittier, 1989). Yarish (1985) noted significant differences in clients' perceived locus of control as a result of their treatment with reality therapy. Other studies have shown positive results with addicted clients (Honeyman, 1990). Parish, a leading researcher on the effects of reality therapy on undergraduate students and teachers, has repeatedly shown its beneficial

effects (Parish, 1988, 1991). Still other studies have shown positive effects with graduate students (Peterson, Woodward, & Kissko, 1991), and in residential youth programs (Bratter, Bratter, Maxym, Radda, & Steiner, 1993).

For many decades, the governments of the world have been dealing with local, national, regional, and international crises. The conventional method for resolving internecine conflict has often involved a gladiatorial style of stimulus-response psychology. Like many public and private schools, nations often function on the supposition that fear is a source of motivation and can produce international harmony if it is sufficiently exploited.

On the contrary, as seen from the point of view of reality therapy, fear is not an effective motivator. When human needs are threatened, suspicious defensive thinking as well as aggressive actions occur. If diplomats were to learn control theory and use the principles of reality therapy, they would have a systematic structure for dealing with each other and might realize that both individuals and nations are motivated to fulfill their needs for belonging, power, fun, freedom, and survival. When these needs are unfulfilled or even attacked, nations often take hostile, destructive courses of action. But if a community of nations could work together to establish an appropriate environment, as a therapist attempts to do, it is more likely that its members will make responsible choices. It is clear that many national leaders operate on a blind stimulus-response philosophy, believing the only way to fulfill their needs is to deny others access to their respective needs fulfillment.

Evaluation

An increasing amount of research evidence validates the effectiveness of reality therapy. It is useful to examine several forms of evaluation. First, compelling evidence for the efficacy of reality therapy lies in the large numbers of professional people who seek credentialing in this field. During 1994, over 500 persons completed the 18-month program to become certified as reality therapists. Certification requires a major commitment of personal time and resources, and the decision to get training is most often made after using some of the ideas learned through self-study or short training sessions. These people come from many of the helping disciplines: teaching, social work, counseling, psychotherapy, corrections, management, and others.

Evidence from case studies illustrates the applicability and effectiveness of reality therapy. Tollefson (1980) described the case of Henry, who had spent 17 years in mental hospitals. A heavy drinker and member of a chemically dependent family, Henry was arrested and first hospitalized for antisocial, hostile, and threatening behavior shortly after high school. He continued to deteriorate, becoming aggressive and impulsive. Abusiveness and lack of cooperation continued to plague him and those around him. Tollefson stated, "He also became untidy" (p. 237), urinated into his own mouth, and became infected playing with his feces. He remained in this condition and even became worse, "hostile, suspicious, regressed, autistic, disoriented, untidy, and sloppy in appearance" (p. 238). When other patients began to harm him in minor ways he withdrew into a corner of the ward, "...coming out only to steal coffee or cigarettes" (p. 238). Anyone approaching his corner was greeted with bellowing, curses, and threats.

The therapist spent many months attempting to establish a relationship by speaking only briefly to Henry. As the therapist continued to ask simple questions, Henry gradually began to answer briefly. Over a period of time, Henry began leaving his corner for brief conversations with the therapist. As success began to be more evident, the therapist used reality therapy procedures more explicitly, asking questions about whether the way Henry

had acted on the ward was helping him. At first, he would put his head between his legs and answer, "No." Eventually, as he was able to conduct more and more self-evaluations of both positive and negative behaviors, he would come into the therapist's office, sit in a chair and formulate plans. In spite of occasional regressions, progress continued. The therapist then insisted that Henry talk normally, rather than in a "crazy" way. Henry gradually began to interact with other patients and made off-ward trips that enhanced his self-perceptions (self-esteem, power, achievement). Eventually he was able to go to the commissary, the library, and the gym without incident. This was need-satisfying to him, and because of his strength and size (six feet five inches), gratifying to the other patients and staff. The therapist was finally transferred, but Tollefson said, "at the time I left the ward, Henry was still functioning well, using his plan and continuing to raise his self-esteem and take more responsibility for his own behavior" (p. 20). Later, Henry wrote a letter to his mother for the first time in ten years.

The case illustrates the use of reality therapy with an extremely disturbed person. It is clear, however, that the system is quite applicable to clients more widely encountered by practitioners.

Honeyman (1990) investigated the effects of reality therapy group treatment on addicts. The self-perceptions of clients were inventoried upon admission to treatment and at the second week, fourth week, and sixth week. Among the significant changes in the clients' perceptions of themselves were the following:

1. Increased self-esteem as a result of coming to sense their own power.
2. Heightened awareness that they were taking more responsibility for their behavior.
3. Deeper conviction that they were unable to control their drinking.
4. Learning to relate to others in altruistic ways rather than exploitive ways.
5. Greater awareness of addict-identity.
6. Realization of the importance of a "higher power."

Honeyman concluded, "As a measure of concurrent validity, the Minnesota Multiphasic Personality Inventory (MMPI) profiles of the 24 clients...[showed] a general reduction in [negative] symptom behavior indicating that clients are in more control of their lives at the time of discharge" (p. 58).

The above data constitute an attempt to get beyond the necessary but highly intellectualized findings of many scientific studies that claim to be based on "hard data." One of the most striking anecdotes regarding the effectiveness of the WDEP system of reality therapy procedures came to Wubbolding in a conversation with a woman who attended, for the second time, a presentation he had made. She stated that by asking her 19-year-old daughter and her husband to evaluate their arguing while traveling in a car to a vacation spot, she was able to have eight hours of pleasant driving. She remarked, "I want to learn more about any system that can do that for me."

Treatment

Reality therapy has been used in virtually every kind of setting, from private practice to prisons. In private practice it is usually short-term, but in institutions where residents are confined for years, it is used as long as clients are required to be in the program or until their rehabilitation is sufficient to allow them to be returned to society. Moreover, the system is applied with individuals, groups, and families.

Individual Therapy

Most clients who voluntarily enter reality therapy receive treatment on a one-to-one basis. As in any therapy, the therapist discusses professional details including the procedures used in treatment. Clients are then asked to tell their story. They often describe their upset feelings and how they are stressed about something that has happened to them, how society is unfair, how they want their external worlds to change. Some already have a sense of inner control and wish to change their own behavior. They admit they are depressed, angry, shamed, or guilty and wish to find better choices. Involuntary clients, on the other hand, are sometimes resistant, hostile, withdrawn, or passive.

The therapist attempts to make psychological contact using skills fundamental to most therapies: active listening, reflection, clarification, and many other processes useful in establishing a desirable therapeutic environment. Allowing clients to tell their story as they see it helps the therapist determine the perceived locus of control of the client, i.e., how much responsibility the client has taken for past behavior and how much responsibility he or she can realistically take for immediate future choices. Having determined the perceived locus of control by patiently listening to the client's perception of his or her story, the therapist helps the client set goals for the therapy by asking what he or she wants to have happen as a result of the relationship. More specifically, it is useful to ask what the person wants to gain from the individual session. The impact of this question can hardly be overestimated. The implicit message is that some change can be made immediately and that there is hope. For the upset, depressed person living in psychological darkness, even a glimmer of daylight is greeted with astonishment.

Focusing on the current behavior of the client, rather than on past history or the onslaughts from the client's external world, helps clients become aware of their actions—the component of their behavior over which they have most control. Depending on the style of the therapist, they are asked intermittently to make judgments on their wants. Are they realistic? Are they beneficial wants, or would having their wants met be harmful to them? Are their overall behavior and their specific actions helping them? They are then asked to make plans that fulfill the characteristics of effective planning. Simple planning sheets are frequently used. In private practice, optimal termination occurs through a joint decision by therapist and client based on whether the client has been able to adopt more effective need-fulfilling behaviors in his or her life.

Group Therapy

Reality therapy is especially applicable to groups. After ice-breaking activities during which people psychologically connect with the therapist and with each other, genuine reality therapy begins.

Wubbolding (1991b) has shown how reality therapy is integrated into the stages of groups (Corey, 1994). At every stage of group development, the needs of the clients should be addressed, though it is not possible for all needs consistently to be met to the same degree. The need for belonging is met in the initial stage in that everyone feels included in the group. The therapist asks what people want from the group. Total behavior is also explored: life direction, specific actions, ineffective and effective self-talk, feelings, and even physiological behaviors. In the next transitional stage of group development, the power need is addressed when anxiety, conflict, and resistance surface. In the third stage, the working phase of group development, belonging is addressed when the group members come to believe that others in the group can be of some help to them. Power or achievement is evident when participants begin to want to change. The leader helps

them decide how hard they want to work at changing their behavior. In the consolidation and termination stage, further planning helps to address fun and belonging needs. Discussion of progress touches on the need for freedom or autonomy. Final closure of the group can come about in many ways, depending on the decisions of the group members.

Marriage and Family Therapy

Reality therapy, based on control theory which explains how the human brain functions, is a preeminent tool for marriage and family therapy. It can also be integrated into systems theory and adds a practical structure and delivery system.

Wubbolding (1988) has described how reality therapy is applied to family therapy. The goals of reality-therapy-based family therapy include the following:

1. *Gain at least a modicum of need fulfillment.* As in all applications, the therapist helps family members fulfill their psychological needs without infringing on the rights of other family members.
2. *Change levels of perception.* Family members are helped to become less judgmental toward each other.
3. *Use "quality time."* Time spent together in a non-critical way, doing activities that are enjoyable, builds a storehouse of positive perceptions that serve as a basis for the healthy interactions required for future problem solving and for negotiating decisions.
4. *Change behavior.* The most visible goal is to help family members change how they act toward each other, both in the therapy session and in the ongoing life of the family.

Because human beings are control systems, i.e., they function as creatures who choose behaviors to satisfy their needs, it is important that the use of reality therapy in family counseling ensures that each member and the family as a unit examine what is desirable, how they are attempting to function as a family, and the effectiveness of their individual total behaviors and the family's total behavior. Only when these preliminary components are present can action planning be successful.

◆ CASE EXAMPLE

Fay, 28, single, has completed two years of college. She works as a buyer for a large department store. She has a history of transitory relationships with men who become interested in her to the point of proposing marriage. She finds them attractive, but when "they get too close" she turns away from them. Although she wants to get married, her friends tell her she is too demanding as well as fearful of intimacy. Approximately one year ago, she was attacked on a street while on an out-of-town business trip. Though not raped, she was jostled, knocked to the ground, her purse taken, and her jewelry seized. After the attack, she experienced an increased fear of journeying out at night even to shopping malls and turned down numerous dates from attractive and eligible men. Her parents, who lived in another city, and her friends urged her to seek psychological therapy.

The therapist reviewed the professional details regarding informed consent, rights and responsibilities of both client and therapist, nature and limitations of confidentiality, possible benefits of therapy, credentials, and fees. A summary of reality therapy was presented, and both client and therapist signed two written statements indicating that the client understood the issues. Fay received one copy, and another was put in her file.

- T: Fay, now that we've discussed the professional details, including the fact that I'll be asking you a lot of questions, I'd like to begin by asking you a very important one. Is there anything that you don't want me to ask you about? Anything I should stay away from?
- F: No, I don't think so. I'm a little nervous, but I'll let you know if you ask about such topics.
- T: OK. Tell me what your parents and friends said when they urged you to come here.
- F: They said that because of the mugging a year ago, I am acting strange, keeping to myself, not wanting to be around them. Kind of withdrawing.
- T: How do you see it?
- F: They're right. What they say is true, but they don't know the whole story. I'm much more afraid than I let on to them. When I have to be out at night, I'm afraid of every shadow. They also don't know something that haunts me even now after about 18 years.
- T: Do you want to tell me?
- F: I've been wanting to get rid of this burden for a long time. But it's hard to say it out loud.
- T: Do you want to get it out suddenly or gradually?
- F: I might as well say it right now. When I was ten years old, I was abused by a friend of a neighbor. He was visiting his friend and I went into the neighbor's house which I did regularly, but this time he was there alone and he touched me sexually, rubbing my genital area.
- T: Did he rape you?
- F: No, it wasn't that bad, but the thoughts have remained with me all these years.
- T: In other words, this is not a past event, it is still very present in your mind and you even have some of the same creepy feelings about it?
- F: Yes. I still feel guilty and ashamed.
- T: I'm not sure you will believe this just yet, but I'd like to assure you, that absolutely, positively, without doubt you were not to blame.
- F: I know that, but I'm not yet convinced as much as I need to be. I've read a lot about this problem and it could be that I'm having trouble with men because of it.
- T: Is that what you tell yourself? "I can't relate to men because of this past experience."
- F: Yes. When I drop some guy that thought goes through my mind.
- T: Does it help you to indulge that kind of thinking?
- F: What do you mean?
- T: Does it really help you to tell yourself that you can't relate to men as you want to because of events that are past and therefore beyond your control?
- F: No, but I can't help it.
- T: Until today you couldn't. But I would like to help you rid yourself of this pain—if you want to work on it.
- F: I want so much to get rid of this pain. It's like carrying around a weight on my shoulders.
- T: I like how you describe it. Maybe you could leave part of the weight here.
- F: I'd like to leave it all here today!
- T: How realistic is it to drop this weight all at once?
- F: Well, I guess not very realistic.
- T: How do you feel at this very moment now that you've talked about it?
- F: Oh, I feel relieved that I said it out loud.
- T: So, already you've tasted relief, dropped part of the weight. Maybe you can work hard so as to drop the rest of it. After all, you have taken two major steps to turn your life around.
- F: I have? What are they?
- T: You came here. That's a major step. How long have you been thinking about getting help?
- F: Years. Maybe three or four.
- T: So you took the big step. Congratulations! You also talked about this. And you've disclosed the details to me so quickly. That's unusual.
- F: Well, it's on my mind. And I learned that many people have had even worse experiences.
- T: I just thought of a third strength.
- F: What is that?
- T: You seem to be willing to work at feeling better.
- F: Yes, I am, indeed.

- T: OK. We'll come back to that point. But I'd like to ask you some other questions. Besides leaving behind some or all of the weight on your back, what else do you want to accomplish through therapy?
- F: I'm afraid to go out at night and I'm having problems with relationships.
- T: Are these the goals you would like to work on? Feeling comfortable wherever you are and more satisfying relationships with men?
- F: Yes, they are.
- T: Can you state what you want from this counseling in positive terms rather than in terms only of what you want to overcome?
- F: I think you just did. But I'll try to do it myself. I want to feel free of a weighty burden, go out at night, and get married.
- T: Get married! You've gone beyond what I expected as a goal. That's terrific!
- F: I might as well aim high.
- T: OK, we have three goals and you've stated that you actually felt better about the abuse, at least for a few minutes. You know, the thought just occurred to me that when you *did* something about the situation, you had some slight relief. That's so interesting.
- F: Why does that seem so intriguing to you?
- T: Because there's a lesson in there.
- F: I think I know it. When I take action, things get better. (Smiling broadly).
- T: Right.
- F: I read the summary of reality therapy.
- T: (Smiling). You're absolutely right. Action leads to change in how you think, what you think, how you feel and even your physiology. By the way do you have any chronic aches and pains?
- F: No, but I have nights when I don't sleep very much.
- T: That doesn't surprise me in the least. All these things go together. And when you change what you're doing, the thoughts will change, your feelings will be better, and I believe you'll sleep more soundly. Now how do you want to proceed? There are two roads. One involves spending a lot of time rehashing the past. Or we could move to the part of your life over which you have control.
- F: Well, I guess I better emphasize what's going on now.
- T: That sounds good to me. If you feel the need, you can talk about past events any time. Talking can always provide momentary relief.
- F: That's good to know.
- T: Now before we end, I have one more question. How hard do you want to work at turning things around?
- F: I'd sure like to turn things around.
- T: Does that mean you'll give it a try or will you really do it?
- F: I'll do my best. Do you think there's hope?
- T: Absolutely...on one condition...
- F: What is that?
- T: That you are willing to work at it.
- F: I said I would.
- T: And you said you would do your best. But let me ask you this. If you were on a plane and the pilot announced over the loudspeaker, "I'll do my best to land the plane," would you feel confident?
- F: I see what you mean. I need to say that I'll give it my all.
- T: I think you are truly motivated to make some changes.

In this initial session, the therapist helped the client decide what she wanted from therapy. He helped her reframe the problems as positive wants, helped her to briefly examine her current thinking, and helped her self-evaluate its effectiveness. The level of commitment was also identified. Throughout the dialogue, he put responsibility on her to decide direction and topics for discussion while suggesting that he could best help her if she was willing to talk about behaviors that are controllable. Finally, he helped her determine her

level of commitment for working at the problem. At the end, he intentionally avoided pushing for a plan, as it seemed necessary to spend more time on the D (doing) and E (evaluation), rather than W (wants) and P (planning) of the WDEP system.

Problem. Fay's problem is not what appears obvious at first glance. Although the problem is indeed connected to the traumatic events of her past, the underlying problem is the unmet need for belonging and a gradual lessening of her ability to fulfill the power need. She is not enjoying her life and feels trapped. Even her survival need is frustrated, as evidenced by her lack of sleep and perhaps by other symptoms not yet brought to the surface. To help her fulfill her needs, it is necessary to define precisely her wants and the degree of energy she expects to exert to satisfy her wants. She is directing her life toward ineffective behaviors when she avoids desirable relations with men and when she chooses "fearing" behaviors such as staying indoors.

Treatment. The WDEP system, based on establishing a friendly, empathic, and hopeful environment, was used to help Fay take more control of her life. The therapist helped her identify attainable wants: letting go of pain and achieving closer relationships, marriage, and freedom from fear.

In later sessions Fay examined her specific behaviors relative to dating relationships and going out of her home in the evening and at other times. She was continually asked to make self-evaluations as to the effectiveness of specific actions. Even though she was already uncomfortable and pained by her present choices, she was asked, "Did it help?" "Did it hurt?" "What was the relationship between what you did and your want for a close relationship with a man?"

Her enthusiastic commitment to change remained, but at times, she showed resistance to success. Paradoxical interventions were used that resulted in lowering her resistance. Resistance is always an attempt to control.

The following exchange took place one month later:

T: Fay, I'd like to ask you about something you mentioned last week. You said that you could not follow through on the plan about looking men in the eye for a few seconds when you passed them on the street or at work when you walked through the store. You said that it was not something you felt comfortable doing.

F: It was not easy. I didn't really want to do it.

T: What impact will not taking these steps have on you?

F: I know, I know. It won't help. But it's more uncomfortable than I thought.

T: Well, maybe we rushed into that plan too soon. It seems you're not ready for that. But it is still a step forward because we both know that we need to work on other things first. Could I make another suggestion?

F: Yes, I'll try anything!

T: This week, will you make a definite effort to avoid men's eyes, even men you feel comfortable around such as the friends who encouraged you to come here, or your colleagues at work? (This is an example of paradoxical intention.)

F: Yes, I could do that. It sounds stupid, but fairly easy.

T: I'd like to ask you what will seem like a strange question. What are other choices you could make to worsen your situation? How could you really make your life miserable?

F: That's a weird question.

T: Yes, I have a lot of them. Could you answer it, just for fun?

F: Well, I could quit my job. I could refuse to date any guy. I could sit around my condo even when I feel like going out.

T: You could turn your back when you talk to men, especially your boss at work or a person you date who you like.

F: Yes, that would really mess me up! (laughs heartily).

T: It's good you can laugh.

F: Well, it is a bit silly not to look at strangers.

T: But it's the best you can do now and what's the difference if you look away?

F: It's just a quirk.

T: What's wrong with quirks? Could you indulge your quirk for a week or so?

F: It might be hard to do that for a week.

T: Well, give it your best shot.

F: OK, no eye contact with strangers.

The therapist prescribed paradoxical situations, and Fay agreed even though she said such tasks were difficult. She rebelled against the therapist because by her subsequent real-world behaviors she looked at strangers and reported that to force herself to avoid their eyes took too much effort and thought. In reality, by rebelling against the therapist, she was doing exactly what he wanted her to do—looking at strangers. She could then use this behavior to show how much control she had in that she had rebelled against the authority of the therapist, showing her strength and actually doing what she had feared doing—looking a stranger in the eye.

Resolution. Fay gained better control of her life and was seen by the therapist for about six months. More effective need satisfaction was evident in her own self-evaluation. She said that she felt better and was able to have long periods when she was not bothered by thinking about the abusive incident. When she experienced mild guilt and shame, she simply told herself that this was part of her life experience and that it would be less of a weight in the future. This self-acceptance lessened the intensity of the flashback.

Looking at men soon became no problem, and she was able to sustain satisfying social relationships with men. She was dating several men when therapy terminated, but she was not interested in marrying any of them. Though she still felt appropriate fear at times when away from home, she took necessary precautions. Excessive fears overtook her occasionally, but did not stop her from performing the tasks necessary to function as an independent professional woman.

Follow-up. A phone call a year later revealed that she had continued to make progress and had become seriously interested in a man. She was fearful, but was considering marrying him and so was delaying a decision. She noted that this new experience indicated immense progress. She stated that occasionally she “gave in to the fear” of going out, but that she was functioning as a “normal human being.” Her parents were quite pleased that she was not permanently scarred by the street attack. She stated that she had summoned the courage to tell them about the abuse she had experienced as a child and her parents were furious. Telling them was a good idea, she said, as she thought it unwise to keep such a secret from them any longer.

◆ SUMMARY

Reality therapy is a comprehensive system of treatment that can be used by any person who deals with others: psychotherapists, counselors, teachers, corrections officers, youth workers, group leaders, parents, business managers and supervisors, administrators, and many others. It is comprehensive because it is based on the way all human beings relate to each other and to the world around them in a free and conscious way. Because of its

down-to-earth nature, it is taught to persons whose professional allegiance is to help at any level.

Because it is based on universal human needs, it is a multicultural approach that allows for the indirectness of some cultures as well as the direct, assertive behavior of North Americans. It can be adjusted to work with clients from indirect cultures and does not require that “other” cultures adjust to it.

Its uncomplicated language makes reality therapy appear to be simpler than it is. To incorporate the system into professional behavior requires time, practice, and effort. In its thirty years of use, reality therapy has undergone major changes. Not only has it been applied to virtually every kind of interaction, but it has acquired a theoretical base and will probably undergo changes in the future. The expression of the procedures as a WDEP system puts flesh and blood on the theory and renders it accessible to people at nearly every level of society.

Therapies that survive in the future will need to be based on solid theory as well as proven effectiveness. Long-term psychotherapy systems have lost much of their popularity and with the growth of managed care are becoming accessible only to the rich. Those systems that will flourish will provide measurable outcomes in relatively few sessions and be applicable to people from all socioeconomic levels of society. These systems must be taught and used by persons other than psychotherapists: teachers, group workers, drop-in center employees, and so on. Reality therapy offers a results-centered approach that can be learned by people who deliver mental health services in virtually any setting.

◆ ANNOTATED BIBLIOGRAPHY

Glasser, N. (Ed.). (1989). *Control theory in the practice of reality therapy*. New York: HarperCollins.

Control theory is integrated with reality therapy in this book of cases. Applications are made to child abuse, grieving, prison, aging, depression, and eating disorders. This book is a useful guide for learning how the theory is used with a variety of issues.

Glasser, W. (1965). *Reality therapy*. New York: HarperCollins.

This book marked the beginning of reality therapy. It explains the basic principles of reality therapy and its early development in the language used at that time. While there have been many extensions of theory and practice, the book remains a classic. It describes how reality therapy was used in a mental hospital and a correctional setting, detailing the astonishing results.

Glasser, W. (1985). *Control theory*. New York: HarperCollins.

Adapting the work of William Powers (1973) to the clinical setting, Glasser explains how the human brain functions as a control system attempting to regulate its own behavior so as to mold the world around it, its environment, in order to gain a desired perception. He describes how human behavior is “total” and states that in thera-

py feelings, actions, and thinking should be treated as a unit. This book is required reading for anyone seeking to understand the psychological basis for the practice of reality therapy.

Glasser, W. (1990). *The quality school*. New York: HarperCollins.

W. Edwards Deming is credited with the renewal of Japanese industry since World War II. His fourteen points on quality are now known worldwide and practiced by excellent companies in many countries. Glasser has applied the concept of quality to education by describing the remedy for an educational system that fails to educate many of its students. In this book, he describes how quality educational experiences can be created by combining the principles of Deming with control theory and reality therapy.

Wubbolding, R. E. (1988). *Using reality therapy*. New York: HarperCollins.

Practicality and usefulness are the themes of this book. The author integrates theory with practice by describing specific applications of reality therapy. The Cycle of Therapy is a design for teaching and using reality therapy that can be applied in virtually any setting. Wubbolding describes specifically how the use of paradox is integrated into reality therapy and presents ethical guidelines for its use. The book is intended as a

supplemental text for courses in theories of counseling and for anyone wishing to learn specifically how to get started using reality therapy.

Wubbolding, R. E. (1991). *Understanding reality therapy*. New York: HarperCollins.

One hundred twenty metaphors, anecdotes, analogies, and similes are presented as concrete

ways to understand control theory and reality therapy. Rather than starting with abstract principles, the author begins with literary examples, scenarios, and stories from everyday life to illustrate central ideas of reality therapy. This book makes the theory of reality therapy come alive.

◆ CASE READINGS

Good, E. P. (1980). Be my friend. In N. Glasser (Ed.), *What are you doing* [pp. 18–33]. New York: HarperCollins.

Rebecca, a young woman, lived with her mother. She had seen other therapists and was quite unhappy with her progress. She felt confused about her future, had no friends, and did not know how to support herself. She also felt uncomfortable about the effects of her prescription drugs. Because of her lack of skills necessary to function as an independent adult, the therapist discussed the “reality” issues and taught her socialization skills such as how to shop for clothes and how to look for friends. A year later she was on the dean’s list at college and reported success in all her activities.

Tollefson, W. B. (1980). Coming out of a corner. In N. Glasser (Ed.), *What are you doing?* New York: HarperCollins. [Reprinted in D.

Wedding & R. J. Corsini (Eds.) (1995). *Case studies in psychotherapy*. Itasca: F. E. Peacock.]

This case demonstrates the use of reality therapy to treat a severely regressed psychotic patient on a back ward of a mental hospital.

Wubbolding, R. (1980). Teenage loneliness. In N. Glasser (Ed.), *What are you doing?* [pp. 120–129]. New York: HarperCollins.

A suicidal young man describes how he isolated himself by spending his weekends depressed and sitting alone in his bedroom for the entire weekend. The therapist helped him to define his wants, examine his actions, and make short-range plans for keeping his drapes open and eventually asking women for dates. He is thus gradually led to choose specific, effective actions, thereby bringing about permanent changes in his ability to fulfill his needs.

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